HSA Core Course: PMO 526
Second Written Assignment

Question:

The American public has modified its expectations of healthcare professionals in the past 25 years, and the attractions to healthcare as a profession are different than in 1960. Describe the major changes in health professions as a result of these factors and explain how changes in the healthcare delivery system have affected these professions.

Take Away Points:

Forty years ago (circa 1960) American medicine was practiced predominantly by white male physicians who received in-hospital assistance for patient care from nurses and a few skilled and specially trained therapists (e.g., speech, physical, etc.). Physicians were generally highly regarded by the social establishment; they were in the top categories of income and were seen as trustworthy by the vast majority of the population. Most physicians practiced as 'generalists' in a setting known as "private practice", were self-employed (singly or in small groups) and worked primarily out of their office. Nursing was composed almost entirely of women and was (with the exception of working in a doctor's office) practiced within the hospital (usually as a ward nurse). Technicians were also predominantly hospital based. Dentists, then as now, practiced predominantly in individual, general care private practice; much of their work involved treatment of dental caries. Pharmacists were businessmen and women, operating 'drug stores'.

As the technology boom grew, health care specialization also grew; physicians became sub-specialists like gastroenterologists, nurses underwent special training to assume roles in Intensive Care Units and technical and therapist staff also tended to hone their breadth into a more narrow area. Medical, nursing and allied health schools were on the cutting edge of teaching in the areas of these specialties and all students were exposed early to the attraction of the narrow field and the high technology in a specialty. There did not appear to be a downside; internal medicine training was so caught up that their board ***reduced*** the training time for general internists (from four years to three) as more and more chose to pursue specialization.[1] By 1970 or so most graduates from medical schools were NOT generalists; the training of nurses and technicians to support the burgeoning technologic boom continued. Dental schools did not produce more specialists and the generalist remained the bedrock graduate and practitioner.

As the costs of medical care rose (partly driven by the technologic boom and partly by other factors), the government and the third party insurers began taking actions to limit the rise of cost. These actions consisted of (a) making health care more available and less costly to the consumers (the patients) through federal payment programs and (b) reductions in the amount of funding or the type of benefits they would cover by various mechanisms of reducing payment to providers and hospitals. As a result of these disparate actions – federal relief from payment making people want more and to believe they had a right to care *versus* the insurers limiting the payment for certain types of care – a growing antagonism developed between the 'patient lobby' and both the health care establishment and the payment industry. Physicians came to be seen as more interested in money than in their patients (at least this perception grew), and the high social standing and trust of the profession began to teeter and crumble. Medical school applications fell both in number and in 'quality' (by the 1980s the top graduates from major universities were pursuing careers in either business or law rather than medicine, probably more for economic reasons than anything else). Nursing salaries did not keep pace and shortages of nurses appeared in certain areas (ICUs, Emergency Departments, etc.) Some thought there was

[1] This action, intended to blend with the new two-year fellowships into a five-year postgraduate training program for specialists, actually created an environment that encouraged more specialization. Second year residents, one year away from a practice setting under the new training requirements, realized they were not ready to assume those responsibilities; they chose to stay in a training slot in a subspecialty.

a shortage of physicians (really a maldistribution); subsequently International Medical Graduates (IMGs) began to increase in number in the country and to take positions not sought after by American physicians; to some degree foreign-born and trained nurses responded to the perceived nursing shortage, taking an increasing number of hospital positions. To address the 'physician shortage' training programs for 'physician extenders' (Nurse Practitioners and Physician Assistants) were developed. These 'extenders' created new possibilities for health care delivery, were a recruiting tool for allied health but they also brought new problems to light (oversight and responsibility, licensing, prescribing privileges, etc.). Many physicians resisted the use of extenders as erosion into their profession. In dentistry, specific 'extenders' began to appear in greater numbers and were generally welcomed into the treatment team. Dental hygienists and assistants initially worked in the dental office but began to pursue sufficient specialization in their niche that they are now able to perform certain procedures without direct supervision. Hygienists require insurance but can extend basic dental care to underserved areas; dental associations do not support their unsupervised work.

As hospitals began to discourage in-patient care except for the very sick, physicians found they had fewer patients in hospital at a time but were spending much more time caring for them and away from their office. Hospitals had need of more skilled nursing staff to care for the sicker patients so their salaries rose and shortages shifted away from the hospital. Therapists and other in-hospital technical staff continued to develop into more specialized niches (e.g., cardiac stress technician, spinal-cord injury therapist, etc.) and to command higher salaries. As more individuals obtained health care insurance the office setting for practitioners became steadily more involved in paperwork. Insurance companies also began taking some steps to try to limit costs for their beneficiaries by adding review steps such as 'pre-authorization' and 'second opinion' requirements before approving expenditures; these steps were viewed as 'second-guessing' by physicians and dentists and were widely regarded as intrusive and something that lowered their personal satisfaction with the profession. Nurses began to take on roles as advice line counselors and managers of managed care review organizations; as a result the nursing and medical professions grew somewhat apart. Pharmacists developed Clinical Pharmacist specialist who were hospital based and who eased the strain on physicians and hospital pharmacists by consultation and patient education programs.

Some hospitals and systems pushed their integration (both vertically and horizontally) in an attempt to maintain some advantage in the marketplace. One unique type of integration was the purchase of physician group practices by hospitals and systems; the result was a conversion of the private practitioner into a staff model employee. This ultimately led more and more physicians to be dissatisfied with their practice and to voice that they would not choose medicine again as a career if they had the choice. Some actually left the profession early.

Over the 1980s and 1990s, the general population came to expect 'high quality health care' as a right, and they defined 'high quality' as any intervention that would be quick, easy and not require them to change their life-styles. Patients were fascinated by the moon-shot and came to think that technology had the answer for all mankind's ills; if they didn't get it from their physician, there must be something wrong. Of course, if there was something wrong (and especially if no one in the system explained what that 'wrong thing' was), there must be grounds for a tort claim or malpractice suit. Claims rose, judgments rose and the medical malpractice industry began making huge contributions to the 'cost' of care by increasing their premiums. In recent years the malpractice issue has led to the closure of one of the nation's oldest insurance firms (St. Paul) and is making coverage so difficult that practitioners in one state are choosing to no longer deliver babies since they cannot afford (or find) coverage. The extensive use of fluoridation in water across the country greatly reduced the incidence of caries and the dental profession has responded by pushing the preventive envelope and becoming more responsive to other dental issues. Dental specialists (orthodontists, periodontists, oral surgeons, etc.) however, are still the minority in the profession. Pharmacists are less likely to be running heir own business and are working for large chains; specialty pharmacists involved in reducing the costs of drug-related

health care and patient education are growing in number (some even becoming heads of managed care organizations.)

Thus, current incumbents are representing the practice of medicine as very unsatisfying and the general public has more to say critically about the profession than praise. The atmosphere has led to another lowering of the GPA for medical school applicants as better students are pursuing other careers. Nonetheless, the number of applicants nationwide is and continues to be greater than the number of seats in our medical schools; most of these individuals appear to be attracted to the study and practice of medicine not for financial gain and they are certainly not the low achievers from college. Dental schools are in financial trouble but their applications are continuing and there is not a major cry from within the profession that all is not well. Dentistry is not losing individuals and the replacement rate seems to be holding (or increasing slightly) the number of practitioners. The role of dental assistants and hygienists in provision of care is broadening and seems attractive to possible recruits. The known sensitivity for all preventive care as well as dental care to economic conditions means that the profession will likely mirror the fiscal health of the nation in the short run. Nursing as a profession seems to wax and wane in attractiveness to young men and women; changes in salary rates as a result of unfilled opportunities may serve to attract some that would not otherwise be interested. Hospitals and outpatient procedure sites (ambulatory surgery, imaging centers, etc.) still require and hire increasing numbers of skilled and specialized technicians and therapists.

There continues to be significant maldistribution of most health care providers and practitioners. Inner cities and very rural areas have not attracted the health professions historically and that is not changing today. These areas remain primarily served by IMGs and foreign nurses. The foreign nurses also continue to occupy a significant number of positions in hospitals; while this abates any nursing 'shortage', it reduces the job market for American trained nurses. As a profession, nursing is struggling to identify its role and place in the spectrum of health care; increasing numbers of nurses are pursuing advanced practice training (clinical nurse specialist, nurse anesthetist, nurse practitioner, etc.) which will bring them closer to autonomous practice while the nation's hospitals say they do not have enough staff to provide bedside care to the patients. Any decreases in the numbers of practitioners will only exacerbate the existing maldistribution. Furthermore, the general public remains skeptical of the fairness and equity of the national health care process and distrustful of managed care and 'administrative medicine' and have recently been 'spooked' by the reports of patient injuries and death as a result of health care. All these factors tend to discourage individuals from entering or remaining active in the health related professions. Nonetheless, patients continue to think that their own physician is practicing with great skill and knowledge; this pertinent fact may continue to draw many into the practice of medicine (and, in a 'coattails effect' into dentistry, nursing and other allied fields) and to make all the health professions remain attractive to our college students.